SLIDING FEE

FMC= Family Medicine Center **Phone #: 254-729-3411**
RFHC= Rettig Family Healthcare **Phone #: 254-729-3740**
KCHC= Kosse Community Healthcare **Phone #: 254-375-7001**
LMC= Limestone Medical Center **Phone #: 254-729-3281**

Please remember that the Sliding Fee Program is a benefit to you. You will be required to follow the policies and procedures in order to remain active in the program.

PATIENT'S RESPONSIBILITIES & PAYMENT REQUIREMENTS:

1. When scheduling your appointment, it is your responsibility to notify the receptionist of your active discount by showing them your Sliding Scale card. If you do not have a card, you may obtain a replacement card at Limestone Medical Center.
2. Clinic patients, who are active on the Sliding Fee Discount Schedule, are expected to pay for their visit after services are received. You will do this at the registration desk on your way out. Payment will depend on the office visit, and the physician's office procedures, the discount will be applied to the total charges. If you are unable to pay your portion you will need to reschedule your appointment or speak with the clinic manager. Failure to meet your payment obligations may result in being dismissed from program.
3. There is a $50 up front nominal fee for all emergency room visits. The balance will be discounted and a statement mailed.
4. Be aware that services provided by the contracted ER Physicians are not covered by the Sliding Fee program. You will receive the physician's bill from a company named Concord.
5. Services provided at LMC, such as Lab (excluding send outs) and Radiology, will be totaled and the discount will be applied at the time of service, payment must be received before services may be rendered. Be aware that if you receive services through the radiology department, you will receive a bill from the contracted Radiologist.
6. You are required to set up a payment plan and make a payment each month towards any past balances owed to remain on the Sliding Fee program, this can be done at the outpatient registration desk at LMC.
7. If you move, or there is a change in your financial situation, you are required to notify LMC within 14 days of the change.

ELIGIBILITY:

1. Applies only to services provided by LMC, FMC, RFHC, and KCHC. This program does not apply to any outside services including Concord Physician, Radiologist, and reference lab billing.
2. Must meet financial criteria as defined in the Board approved Discount Schedule.
3. Must provide a valid picture I.D., proof of address, and verification of income with completed Sliding Fee application. Acceptable income verification includes prior year tax returns, current paycheck stubs, written verification of wages from employer, unemployment letter, social security check, bank statement, disability check, or a letter of eligibility for cash assistance.

FINANCIAL CRITERIA:

Your eligibility and discount will be based on the current federal poverty guidelines. This schedule will be reviewed at least annually to reflect any changes to the federal poverty guidelines.

COVERED SERVICES:

1. Applies only to services provided by LMC, FMC, RFHC, and KCHC. This program does not apply to any outside services including Concord Physician, Radiologist, and reference lab billing.

SLIDING FEE PROGRAM

Turn in applications to the Limestone Medical Center's Outpatient Registration desk Monday-Friday between 8:30am-5:00pm. *(Applications may be turned into the ER 24/7 as long as ALL required items listed below are provided).*

* Primary Applicant MUST provide:

→ **A Valid U.S. Picture ID or TX Driver's License**

→ **Proof of Address:**

- *Mail with patient's name & address*

→ **Proof of Income** ***(provide at least ONE of the following):***

- *Prior year tax return*
- *Current paycheck stub*
- *Written verification of wages from employer*
- *Unemployment letter*
- *Social Security check*
- *Bank statement*
- *Disability check*
- *Letter of eligibility for cash assistance*
- *LMC Support Letter (Ask for one when picking up application)*

CONFIDENTIAL SLIDING SCALE FEE APPLICATION

Please read the following information carefully: Patients must provide the required items as outlined in the Sliding Scale Procedures when turning in this application.

APPLICANT'S INFORMATION			
Applicant's Name:		Date of Birth:	
	Sex: □M □F		
Address:	City:	State:	Zip:
Home Phone #:	Cell Phone #:		
Do you have health insurance?: □Yes □No (If yes, please provide coy of Insurance card)		Are you employed?: □Yes □No	
Place of Employment:		Employer's Phone #:	

HOUSEHOLD MEMBERS				
LIST ALL MEMBERS OF THE HOUSEHOLD BELOW	**DOB**	**RELATION**	**List the Health Insurance this family member has**	**Is this family member employed?**
1.				
2.				
3.				
4.				
5.				
6.				
7.				

HOUSEHOLD INCOME

Please select the one you will be listing ☐ Annual, ☐ Monthly, or ☐ Weekly / Bi-Weekly income amounts below.

Total in for Income for Household	***SELF***	***SPOUSE***	***OTHER***	***TOTAL***
Gross Wages, Salaries, Tips, Self-Employment, Unemployment, public assistance, etc….				
			TOTAL INCOME:	

☐ I am not participating in any indigent programs.

☐ All information on this application is accurate, and complete, to the best of my knowledge.

☐ I have read the Sliding Scale Fee Procedures & Policies. I understand that I am responsible for all remaining charges for LMC, FMC, RFHC, and KCHC.

☐ I understand I must re-apply every 12 months from approval date.

X____ ______________________________

Signature of Applicant/ Responsible Party **Date**

Official Use Only

☐ ID/ DL **☐ Proof Of Address** **☐ Proof of Income:**__________________________________

Verified/ reviewed by:__________________ **Discount:** ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% **Expires:**______________

Limestone Medical Center
701 McClintic Drive
Groesbeck, TX. 76642
254-729-3281

Sliding Scale Program- Support Letter

*** This letter may be used in place of "Proof of Income" for applicants who do not have a source of income & are financially supported by a friend/ family member.*

Date: ____________________

PLEASE PRINT

I, ______________________ (Supporter), financially support ______________________ (Person applying for the Sliding Scale Program) by paying all living expenses he/she incurs because he/she has no source of income. I provide food, shelter, and other amenities that may not be listed above.

______________________	______________________
Patient's Printed Name	*Patient's Phone Number*
______________________	______________________
Supporter's Signature	*Supporter's Phone Number*
______________________	______________________
Witness Signature	*Witness's Phone Number*